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MAY
1977

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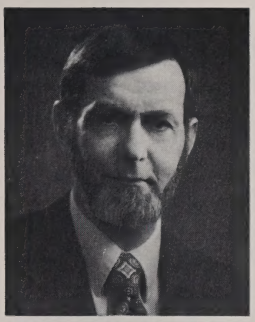

Brùce B. Stoler, M.D.

Your President's Page

"Summing Up"

As noted by others in these pages in the past, it is difficult indeed to move a medical society as large as ours into new channels in a single-year presidency. But I was fortunate to have had Gardner Cox as president during my term as president-elect and, when he agreed with my ideas, he often put me in charge of their implementation. As a result, some of my pet projects were already on track when I assumed the presidency. Conversely, some of his ideas for PSRO cooperation, cost-containment and zero-based budgeting, with which I wholeheartedly agreed, could be continued and expanded during my term.

Certainly there have been disappointments. High on the list of failures we would have to include our inability to secure representation for HDMS on the Board of Directors of the Western Mass. Health Planning Council and our inability to persuade the MMS to implement programs which had much support in Hampden such as the Blue Shield Resolution. But I believe we can point with pride to some positive accomplishments: e.g., the germination and growth of an active Membership Committee, the adoption by the membership of a commitment to the detection and rehabilitation of disabled physicians, an increase in the involvement of hospital-based and foreign-trained physicians in the affairs of the Society, the assignment of our MMS councilors to represent specific HDMS members and to be accountable to them for their actions, a separation of editorial and policy-making constituency of the Hippocrat through the formation of the Publications Committee, and a closer liaison with the Academy of Medicine. We have also seen the strengthening of some of our more traditional activities: e.g., media relations, office structure and legislative activities.

I wish to thank Vivian Purdy, Fran Weiss, the officers, the executive committee and all those committee chairmen and members who have labored to bring about what I consider to have been a very successful presidential year. I especially want to commend Paul Moore on the eve of his retirement as Treasurer for his many years of dedicated service to our Society.

As president I have made a conscientious effort to involve Rocco Verrilli in all discussions and decisions and to permit him the same latitude and freedom of action which were granted to me as president-elect. And now it is time to pass the baton to him and to wish him god-speed.

Bruce B. Stoler, M.D.
HDMS President 1976-1977

The President Elect Speaks About Necessity

A few words, not of bland reassurance, but about necessity . . .

We all know of the difficulties that face the medical profession today and in the foreseeable future. Forces not necessarily evil, but certainly misguided, have gathered to attack medicine on all sides of the perimeter.

Politicians, press, and pressure groups are on every side except ours and the patient's. The result is the destruction of mutual trust which is the basis of the patient-physician relationship. It leads to loss of patient's respect and physician's self-respect. The social planners want to demote the physician to the lowest denominator: the unthinking, unfeeling technician.

Physicians do not seek to adopt the adversary stance which seems to permeate and sustain many of the structures of society at large—legal, political, and the press.

The physician's model goal for existence is to preserve and enhance, not destroy.

Let us remind those self-created adversaries that many years ago the medical profession developed just those programs that the social planners have suddenly discovered—continuing medical education, peer review, and consultation. The last has now been given a new name—the second opinion.

Enough of the depersonalization with which the bureaucrats strive to turn people into objects. We are not vendors but physicians. Our patients are not consumers or receptacles but human beings.

How can we counter all this? We physicians have the best constituency of all: our patients. Let us continue to give our patients the fullest attention, the greatest concern, the best medical care. In return, they will give us their trust and their support for continuation of a one-to-one relationship. It is the main foundation of our uniquely American system of medicine.

GENTLEMEN UNITE. Without the strength of unity and without the support of our patients, we will become vendors.

Rocco A. Verrilli, M.D.

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Annual District Meeting April 26, 1977

The Annual District Meeting of the Hampden District Medical Society, the 137th Annual Meeting, was held April 26, 1977 at Storrowtown Tavern.

The minutes of the February 15, 1977 District Meeting was read by Dr. Stoddard, and approved as read.

Committee Reports had previously been printed in the April issue of the Hampden Hippocrat and it was moved, seconded and passed that the reports be accepted as presented.

No new business was presented.

Treasurer's report by Dr. Paul T. Moore was presented with the dues recommendation being that no change in the $92.00 per year level be accepted. The treasurer's report was accepted with the amendment presented by Dr. James Allan that the budget of the HDMS be published one month prior to the Annual District Meeting in order that the membership could make an intelligent vote when accepting the treasurer's report.

Dr. Howard Simpson presented the Auditor's Report and this was accepted as presented.

A moment of silence was observed in memoriam for the passing of the following physicians: Joseph Schiff, M.D., Longmeadow; Euguene G. Boss, M.D., Springfield; Francis I. Haggerty, M.D., Springfield; James L. Smead, M.D., Greenfield (Past President HDMS); Arthur N. Ball, M.D., Springfield; Eoline DuBois, M.D., Springfield; John T. Branciforte, M.D., Palmer; Myles H. Illingworth, M.D., Springfield; A. A. Palermo, M.D., Sarasota, M.D., Florida, Past President HDMS); Daniel A. Hart, M.D., Suffield, Conn.; John W. Greany, M.D., Springfield.

Presentation of Golder Certificates commemorating Fifty Years in Medicine were made to the following physicians: George D. Becher, M.D.; Kenneth S. Fletcher, M.D.; Arthur J. Logie, M.D.; Daniel R. Wheeler, M.D.

Presentation of certificates to new members was then carried out.

Awards were made by presentation of plaques by Dr. Stoler to Sy Becker, Radio WSPR; Austin Kenefick, Springfield Daily News.

Dr. William Coen presented a plaque of appreciation to Attorney Benjamin Novak for his work in setting up the Dr. & Mrs. Max Millman Memorial Fund as a scholarship trust.

Dr. Harry N. Memery presented the recommendations of the Nominating Committee to the membership. It was moved, seconded, and passed that the report of the Nominating Committee be accepted. Your new officers and committee chairman are listed in the front of the present Hampden Hippocrat.

Dr. Stoler gave his President's Address and introduced Dr. Rocco A. Verrilli, newly elected President, who spoke to the membership regarding unity and the need to preserve the physician-patient relationship.

Dr. Stoler closed the meeting.

Respectfully Submitted,
Philip B. Stoddard, M.D., Secretary

Ernest A. Byron, Jr.

SPRINGFIELD

HDMS Auxiliary Activities

Immunization of children has become a pet project of Carol Yorzyk. Carol sent a letter to the Superintendent of School in 24 towns of Hampden County. The letter asked the Superintendent if the Auxiliary could distribute to the parents of incoming kindergarten students an immunization flyer (printed in English and Puerto Rican Spanish). The flyer explains: (1) the need for immunization; (2) the ages of various shots; (3) encourages those due for shots to contact their doctor or clinic to get the necessary immunization. Twelve Superintendents have requested the flyer; and 5,000 have been distributed thus far.

Spring cleaning? . . . Roxy Zacarian (567-5777) is still collecting adult clothing for Northampton State Hospital.

The last Board meeting of the year was held at the home of Carol Yorzyk on April 4. Two presentations were on the agenda. The first by Glen Ives, Director of the Springfield Science Museum, explained in detail the museum's plans for the proposed health room. The Board has made a commitment to this community health project. Mrs. Vivien Purdy gave a short talk on Bay-Pac. Bay-Pac—The Bay State Physicians Political Action Committee—was organized in 1962 as a voluntary non-profit, non-partisan and unincorporated political action committee. Bay-Pac's purpose is a method by which physicians can organize to give financial aid to candidates for political office.

The response to the program on Child Abuse and Neglect has been gratifying. The clergy, in particular, has shown great interest.

At the annual luncheon on May 10 the new board was installed. They are: Mrs. Robert Bye, President; Mrs. Richard Miller, President-elect; Mrs. Bruce Stoler, Treasurer; Mrs. Carl Janovsky, Recording Secretary; and Mrs. George Pelletier, Corresponding Secretary. After lunch Mr. Richard Muhlberger, Director of Fine Arts, and George Walter, Vincent Smith Museum, gave a talk.

The Auxiliary's scholarship coffers are $800 richer due to the response of over 280 persons who attended the Jazz Concert.

Polly Miller is busy gearing up the Welcome Wagon to meet and greet the expected influx of medical families this summer. Let Polly know of any new family. This is simply a welcoming visit. No pressure to join the Auxiliary is applied.

In the past year 300 bills have come before the State legislature and or committees. How many of them are you familiar with? Shouldn't we all be better informed? Write: Mary Ann Shea, 22 The Fenway, Boston, MA, for the weekly legislative report.

Flooding of the allied health careers job market has forced the state Auxiliary to direct us to seek fewer scholarship recipients. Therefore, only 25 applications per school have been sent to the schools. So far this year 130 applications have been received (last year 170). The students applying appear to be of a higher academic calibre. The Auxiliary will distribute $4,000 of scholarship aid including renewals and new scholarships.

Mrs. Robert H. Nenninger

Nominating Committee Report

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Area Health Planning, Franco Navazio

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AMA Hospital Medical Staff Leadership Workshop

During 1977 the AMA will sponsor six regional workshops for hospital medical staff members. The brochure lists the dates and locations and the agenda items. Among the numerous topics are medical staff management problem solving and medical risk management.

As hospital organization and administration become more complex and as professional liability continues to concern all physicians, these two subjects will require increasingly more attention from physicians.

For further details, contact: Mr. Jerry Krautkramer, Department of Hospitals and Health Facilities, 535 North Dearborn Street, Chicago, Illinois 60610; tel. 312-751-6657.

Legislative Committee Action

For your information the HDMS Legislative Committee has been working hard to express medicine's views on multiple bills brought before the Massachusetts Legislature. Below is the committee's report.

Report of the Legislative Committee of the Hampden District Medical Society to the Legislators in Hampden District

Dear Legislator:

The members of the legislative committee of the Hampden District Medical Society have held several meetings and have carefully reviewed the many proposed bills concerned with health care. We have individually had discussions with our colleagues and after much deliberation, we have selected ten bills which we, representing our district medical society, would like to formally support or oppose.

Although we are free citizens and your constituents, we would like to offer you professional advice based on our expertise, and as local representatives of an honored profession of which we are proud. We represent the physicians who are practicing the art and science of medicine in Hampden District and we strongly resent being referred to as "vendors" or "providers" of health care.

We have realized all along that in any large group or society, including our profession, there is bound to be a certain percentage who do not live up to ethical standards and therefore we, like any other group, must live by rules and regulations. We have been accused of not policing our own. We feel that this accusation was unjust because we never had adequate means at our disposal to do so. Therefore we have favored and supported the new Board of Registration and Discipline in Medicine. However, while anxiously awaiting the public hearings and before the new board has gotten off its feet, so to speak, we find that the so called "consumer representatives" are asking that the composition of the board be changed, giving them majority control. We strongly oppose House Bill #44. We can only see this act as an effort to create another powerful state bureaucracy which would have majority control without adequate expertise. We feel that this proposed bill is unwise, dangerous and shows a complete lack of faith and trust in executive appointees who have supposedly been carefully screened.

We also vehemently oppose House Bill #239, an act to inform the public of powers of Boards of Registration within the division of registration. We

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believe that the public knows that all physicians are licensed by the State of Massachusetts and that there is a Board of Registration. The disciplinary powers of the Board of Registration and Discipline in the proper spirit, should be directed at those few physicians whom we have mentioned above. This bill again would be directed to the small percentage of patients, known to all of us, who would be incited to file unnecessary nuisance complaints against physicians. The spirit behind this act is punitive and unjustifiable.

The committee supports Senate Bill #386, immunity for professional societies and their members, and also Senate Bill #388, immunity for members of the Board of Registration and Discipline in Medicine. We all realize that one of the major problems of self discipline in the medical profession is one of accusations, counter accusations, suits for defamation of character and the like, with endless legal hassles. Immunity would solve a part of the problem. We would like to emphasize however, that in the spirit of the judicial process, the accused should be guaranteed the rights of a fair and full hearing with legal representation.

We strongly oppose House Bill #46, assessing providers for consumers in cases heard before the rate setting commission. This act would establish a fund for consumer representation based upon the revenues received by the providers. It would seem that a consumer fund, if one need be established, should come from general state revenues rather than taxation of any particular group or profession. We therefore strongly oppose the establishment of such a discriminatory fund.

The committee would also like to formally oppose Senate Bill #370, an act to establish an experimental neurosurgery review board. We feel that Psychosurgery has been shown to have significant beneficial results in certain patients. Criteria for the selection of these patients have been formulated by the American Association of Neurological Surgeons and the Congress of Neurological Surgeons. We feel that adequate controls over Psychosurgery do exist and no further formal controls need be created. The benefits of Psychosurgery in well selected cases have enabled many people to return to relatively normal life styles. To deny patients such as these the advantages of modern neuroscience by interposition of a minor bureaucracy between the patient and surgeon, is to perform a significant misdeed to the suffering individual. Of the 9 members of the proposed board, the only members with any relationship to the field in question are the neurosurgeon, the neurologist and the psychiatrist. These individuals would usually be the members of institution committees to decide upon indications for psychosurgery and would possess the knowledge and experience to reach a rational and ethical conclusion.

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We further oppose House Bill #47, an act permitting pharmacists and the Board of Pharmacy to warn patients regarding drugs. We feel that this proposed legislation carries a high potential of causing harm to the very patient that it is intended to protect. To intelligently advise a patient in the "safe and proper use" of prescribed medication requires not only knowledge of the pharmaceutical properties of the drug, but a first hand understanding of each patient's background and his current clinical problem. It is equally important to know the nature of all other medications the patient is currently taking. A pharmacist does not have this information. There is no doubt that a well informed and conscientious pharmacist may be aware of many of the common side effects of a particular drug. For the pharmacist to dispense "all the warnings" as requested by this legislation, would undoubtedly result in frightening many patients to the point of not taking their medication. The instructions given by the pharmacist may differ slightly from those given by the physician and may result in the patient being alarmed and confused. In short, instructions and warnings to the patient to guide him in the use of his medications are primarily and irrevocably the responsibility of the patient's personal physician. This responsibility cannot under any circumstances be abrogated by legislative fiat.

We in Hampden District feel that House Bill #655, an act providing that all health insurance policies include coverage for complete maternity care should be opposed. This bill would unduly increase the insurance rates for a significant segment of our population which does not require this type care. Many members of our Society were in complete opposition to the definition of "complete maternity care" stated in lines 6 and 7 of the bill: "treatment associated with voluntary control of reproduction." This portion of the bill, as you know, is highly controversial and highly objectionable to some on religious and moral grounds. Therefore we did not feel that as a Society, we could endorse legislation couched in such terms. We would endorse a revision of the bill excluding the objectionable portion and stating that all health insurance policies must offer an optional coverage at reasonable cost for complete maternity care.

Senate Bill #379, a bill to amend the determination of need program is unwise and unnecessary. The Rate Setting Commission already effectively controls the number and distribution of such expensive medical equipment. Sections 4 and 5 of this bill would create a state bureaucracy which would duplicate the existing federally mandated Health Services Agencies. This is clearly unnecessary and an expense the taxpayers can do without. We therefore urge you to oppose Senate Bill #379.

Lastly we would oppose Senate Bill #491 which would force medical personnel to report cases of child abuse and neglect. The bill as written is punitive rather than constructive and the penalty of $1000.00 or 2-1/2 years in

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prison is inordinately large. Child abuse and neglect is a medical problem. It requires constructive work with families for its solution. The main thrust for people in the health field at the present time is to gain the confidence of the public and to reassure them that the medical profession has as its aim, constructive rather than punitive action. The bill as written does just the opposite, treating it in a punitive way. It would probably increase rather than decrease the difficulty of finding and correcting instances of child abuse and neglect. A correct approach involves the physician and family education as well as the availability of skilled health care teams to work with involved families.

As of April 18, 1977, the State Legislature took the following action:

S-370—Establishing a Neurosurgery review board. Committee on Health Care recommended "ought not to pass." Senate accepted committee report.

H-46—Assessing health care providers and establishing a fund for consumer representation before the rate setting commission. Committee on Health Care voted, "Ought not to pass." Report accepted in House and Senate.

We sincerely hope that the information and professional advice contained in this letter will be informative and especially helpful to you in your discussions and deliberations. If we on the Legislative Committee can be of further assistance to you, please call Mrs. Purdy at District Headquarters.

Sincerely yours,

Legislative Committee
Hampden District Medical Society

A Brief Follow-up on the Featured Article in Jan. 1976 Issue

In its first order of business the merged medical staff of Baystate Medical Center has elected its first officers.

Named as president of the 500 member staff was Dr. Franco R. Dinale, chairman of the medical center's department of anesthesiology.

Elected to other offices were Dr. William M. Cloud, vice president; Dr. Eckart Sachsse, secretary; and Dr. Howard M. Ledewitz, treasurer.

Wesson Memorial Hospital and the Medical Center of Western Massachusetts merged last April to form Baystate Medical Center, the state's second largest health care complex with 1,036 beds and 3,200 employees.

Joseph W. Bradley
BSMC Public Relations

Now ... the AMA brings CME to you!

As you're aware, state medical societies, specialty societies, and other medical groups in increasing numbers are making continuing medical education (CME) a requirement for membership. Already some state licensure boards are requiring CME for relicensure.

Recognizing its importance to members, the AMA has greatly expanded its CME programming. In 1977, your AMA will offer 15 regional meetings, as well as scientific programs at the Annual convention and Winter Meeting.

These new regional meetings make it easier, more convenient for you to fulfill your CME needs by bringing the programs closer to your hometown and scheduling them on weekends to avoid interference with your practice.

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In Memoriam

John V. Greany, M.D.
Died: March 30, 1977 in the Mercy Hospital, Springfield, at age 79.

Dr. Greany had been a native of Springfield and was a graduate of the Springfield Public School System, Tufts College (1920), and Tufts Medical School (1924). He served a two-year internship at St. Mary's Hospital, Waterbury, Connecticut in 1924 and 1925, following which he did some postgraduate work in surgery at the University of Pennsylvania (Philadelphia) and in England. He was appointed surgeon for the City of Springfield from 1929 to 1933 where he was predominantly in charge of all surgical welfare patients at the Springfield Municipal Hospital. He was appointed to the Surgical Staff of Mercy, Wesson and Springfield Hospitals and also the Cancer Division at the former Westfield State Sanitorium. He retired from practice in 1973 and was honored on the occasion of his retirement from the honorary staff of the Mercy Hospital 4/7/76. Dr. Greany was a member of the Mass. Medical Society, Springfield Academy of Medicine and a Fellow of the American College of Surgeons. He had also been a member of the Public Health Council and the Springfield Lodge of Elks.

Respectfully submitted,
Jesse G. Hafer, Jr., M.D.

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Editorial From The AMA

If we in organized medicine say "no" to any form of National Health Insurance, we're going to be outshouted, outdone—and perhaps undone—by the labor-liberal crowd that has a strong "yes."

Certainly the Carter Administration will have a "yes," once three preconditions are met. These preconditions are reorganization of the Department of Health, Education, and Welfare (already initiated), welfare reform (for which a task force has been named), and cost controls (as embodied in the proposed ceiling, or "cap," on hospital-cost increases).

Proof of the Administration's commitment to NHI is furnished by HEW's appointment of an Advisory Committee on National Health Insurance Issues. The 29 public members include Edgar T. Beddingfield, M.D., chairman of the AMA Council on Legislation, but also two outspoken labor leaders—President Leonard Woodcock of the United Auto Workers and Bert Seidman of the AFL-CIO—plus other liberals.

In announcing the appointments, HEW Secretary Joseph A. Califano, Jr., said NHI "is a cornerstone in the structure of the President's domestic policy."

So we can be on the lookout for the Administration to offer an NHI proposal next year—and strive to get it enacted before the 1980 elections.

This proposal, if not basically a facsimile of the Kennedy-Corman-labor NHI bill, is likely to defer to its principal elements—the way the 1976 Democratic platform did.

What is the best way—really the only way—to head off this danger?

Well, no less conservative a U.S. Senator than John G. Tower of Texas has stated, "The most viable means of avoiding the Kennedy-Corman version of socialized medicine is to oppose it with more reasonable alternatives."

And as Congressman Paul G. Rogers of Florida—an influential figure in health-care legislation—has said, "It is my view that to simply oppose legislation without offering alternatives rarely is an effective approach on Capitol Hill."

The American Medical Association's comprehensive health insurance measure is the reasonable alternative.

The AMA recognizes that most of the general public (the ultimate arbiter on the issue) wants an NHI bill. The majority, according to a recent Gallup Poll, want a form of it that is largely free of federal involvement and funding. A plurality—39 per cent of the people polled—want a version that tallies pretty much with the AMA bill.

The AMA measure would preserve the private thrust of care and its financing. It would depend principally on employer-employee contributions and apply federal funds only to the poor and jobless. These funds, mind you, would come from general revenue—not from any special levy, like the already runaway Social Security tax.

In short, here's a bill that would preserve our professional freedom while honoring the public's wants and needs. We can't let the labor-liberal forces have the NHI ball to themselves. We have to be on the field fighting for it—and fighting as a great, strategic team.

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Spring, the span from birth to tribulations;
Summer, the interlude of youth, passion and vigor.
Autumn, an oasis, to harvest upon our deeds and
hitherto attainment;
The Winter of our life, a period of reflection, what was,
what is, and where we now are.
Be not sad, for if you have but touched a single
soul and healed a festered wound,
you have done much, be content.

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Photo Scenes From The Last HDMS Meeting.

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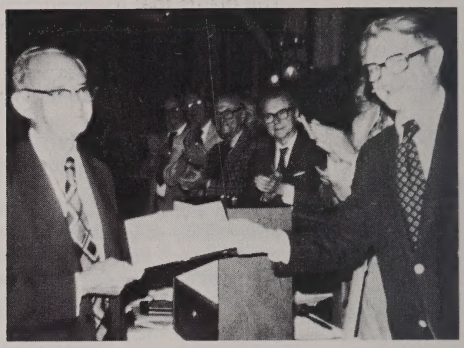

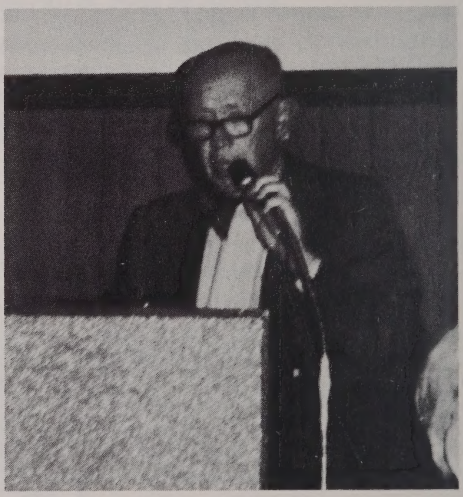

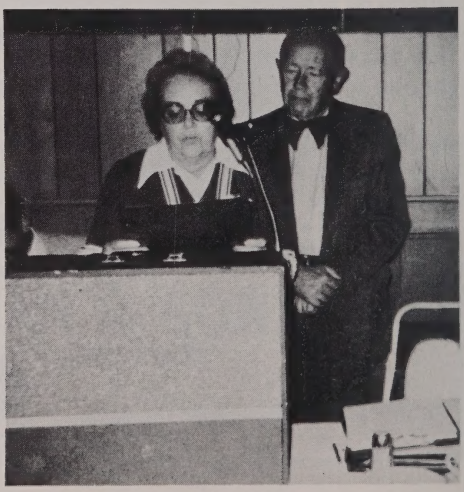

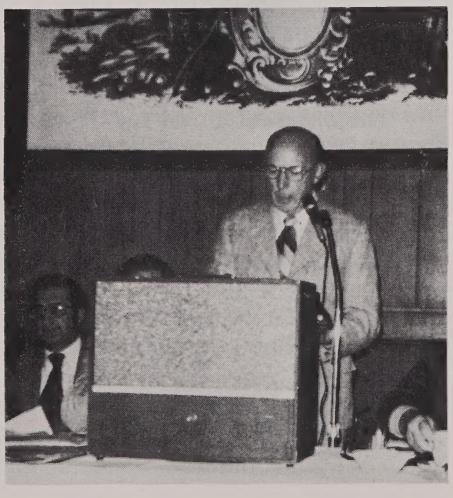

Executive Committee

April 19, 1977

The Executive Committee met on Tuesday, April 19, 1977 in the Conference Room of the HDMS.

Present were Drs. Stoddard, Walthall, Teale, Stoler, Verrilli, Magill, Smith, Moore, Lynn, Abrams and Mrs. Purdy.

The minutes of the March 15, 1977 meeting were read and approved as read by the committee.

Correspondence

The magazine *Private Practice* wrote asking for releases from HDMS to be utilized by their publication. Upon motion duly made and seconded it was voted in the negative.

A letter of appreciation was sent from the Community & Regional Opportunity Program, Inc. for Dr. Simpson who spoke to the elderly on "Project Healthy." This was informational.

Wing Memorial Hospital wrote asking the HDMS to refer any suitable physicians to them as they are recruiting primary care physicians. This was informational.

Western Massachusetts Health Planning Council sent a synopsis of a certificate of need application for a boiler plant at the Wesson Women's Unit. This was discussed and considered informational.

The AMA is sponsoring a series of Hospital Medical Staff Leadership Workshops during the coming year. This will be printed in the May issue of the Hampden Hippocrat.

Old Business

The report from the Springfield Academy of Medicine's questionnaire was given by Dr. Magill. A total of 351 questionnaires were sent out to academy members. The number of cards returned were 127. Answers to question 1: yes—98, no—24, and 5 members wanted more information. The second question on finances were: yes—79, no—17, and no answer—31. Discussion followed and it was agreed to have legal counsel and discussion with the auditor as to the "no profit" status if amalgamation takes place.

Responses from hospitals on both the screening clinics and the thymus radiation problem were read. Ludlow Hospital still hasn't responded.

No response has been received from Dr. Culver on the Continuing Education Program. However, personal record books for gathering CME credits have been sent to all members of the Massachusetts Medical Society.

The old question of the Garcia vs. Texas State Board of Medical Examiners was once again studied. Dr. Stoddard gave a report on recent correspondence that has transpired between Dr. Mosig and the American Medical Association. It was suggested and voted on to send the material to the Massachusetts Medical Society asking for legal counsel on this problem. Mrs. Purdy was instructed to look up old minutes and any other correspondence that may have taken place previously.

Dr. Abrams, Chairman of the subcommittee on House Calls assigned by Dr. Stoler in March, gave a report of his meeting with the Visiting Nurse Association, the Council on the Aging and the Home Care Corporation. Further study and inquiry will be made by the committee and will report to the Executive Committee at the May meeting. Dr. Kennedy, medical advisor to the Visiting Nurse Association will be contacted and the committee will meet with him.

Dr. Stoler gave his President's report. His report was concerned mostly with the Pilot Community Health Program in Longmeadow. A questionnaire was sent out to 3,000 residents and to 317 physicians in the area. Over 700 returns were received. Each of the questions asked were gone over by the committee and Dr. Stoler replied to the questions as he had gone to the Town Hall to study the questions and answers. This requires no action.

Mrs. Purdy reported on the meeting she attended of the New England Medical Societies and the New England Delegates to the AMA. Liability legislation of the various New England states had been discussed. Dr. Burden reported on "Our Days in Court" as the Massachusetts Medical Society has been before the courts seven times this past year. Seven thousand pieces of mail have been sent from the offices of the HDMS during the past year.

Dr. Moore reported on three delinquent dues paying members. He recommended loss of membership if these dues are not paid by the Annual Meeting of the state society. Each of these physicians will be so notified before the annual meeting.

The letter that Dr. Stoler had sent to Dr. Burden regarding discrimination against medicaid patients had been sent to the committee previously. Some discussion followed and this was considered to be informational at this time.

The Baystate Nutrition Center on Bridge St. was discussed. It was suggested that a letter be written to Baystate Medical Center asking if this center is hospital sponsored and if so, is the hospital aware that patients cannot get reimbursed by third party payors.

The Publications Committee which is chaired by Dr. Simpson held a meeting recently and discussed changing the name of The Hampden Hippocrat to *The Hippocrat* and include the other three district medical societies from the Western section of Massachusetts. The Presidents of Hampshire, Franklin and Berkshire have already been contacted for their opinions but so far no answer has been forthcoming. Further study and discussion will ensue and reports will be made to the Executive Committee.

A medical group of the physicians in Westfield was robbed recently. The thieves took medical records of patients seen that day and their appointment book. They asked if they could ethically place an ad in the local newspaper to their patients. The committee agreed with this.

Dr. Verrilli reported on the meeting he and other Presidents-Elect had with Blue Shield in Boston. The meeting was a public relations effort to explain Blue Shield purposes.

The meeting was adjourned at 9:40 P.M.

Philip B. Stoddard, M.D.
Secretary

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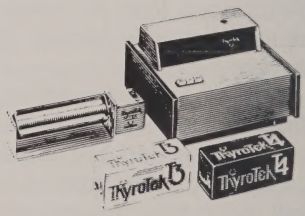

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From HEW—
Aging: A Challenge to Medicine

The health care system and other vital American institutions were not prepared for the demographic revolution of the 20th Century that saw the population of older Americans grow seven-fold while the general population only tripled.

This human triumph of increased life expectancy is clouded by the situation created because the nation was not prepared for a "sudden" increase of citizens 65 and older—from 3 million in 1900 to 23 million today.

The major task before the nation is to adapt its social institutions to the needs of older people while, at the same time, it meets the needs of the younger population.

The prospect of the older population growing to 30 million by the year 2000 poses an especially serious challenge to the health care profession—from the "pure" research scientist in the laboratory to the practitioner in his consulting room.

The profession is ill-prepared to meet that challenge, as indicated by a lack of training in geriatric medicine—not even fundamental education in this field is offered by American schools of medicine.

A survey of 99 medical schools in 1970, for example, found that 50 made no mention of geriatrics in their offerings. And, of the nation's 114 medical schools, only 32 offer electives in the subject.

Until January of this year the nation in which one out of every 10 citizens is 65 years of age and older had not a single endowed chair in geriatric medicine. Today, there is one—the Irving Sherwood Wright Professorship in Geriatrics at the New York Hospital-Cornell Medical Center in New York City.

Let us hope that establishment of that chair, by a $1 million endowment from the Gladys and Roland Harriman Foundation, signals a new academic emphasis and that the Wright Professorship is the first in a series of similar teaching and research positions to provide needed leadership in geriatrics throughout the country.

Medical education today is marked by serious shortcomings: No medical school requires that all its students receive part of their training within nursing homes, long-term care institutions, or in home-care programs. There are but two formal medical school training programs in geriatric medicine and very few centers in which any sort of training for research in clinical gerontology can be obtained. In other words, medical students get little or no sophisticated teaching regarding the medical problems of the elderly. This lack is reinforced by a prejudice toward the aged often displayed by teaching and practicing physicians.

The obvious conclusion is that the medical profession, as represented by its educational establishment, is not preparing itself to serve a rapidly growing population with special needs for health care that become more pressing every year.

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There are indications that the general public is moving ahead of the medical profession in recognition of the special problems of the elderly and in taking action to solve them. Congress, as representative of the people, established the National Institute on Aging (NIA) as the 11th of the National Institutes of Health after finding that: "No American institution . . . has undertaken comprehensive systematic and intensive studies of the biomedical and behavioral aspects of aging and the related training of necessary personnel."*

The Institute, which began operations last year, sees its main role as correcting this lack by supporting a comprehensive program of research and training on the variety of factors—biological, medical, social and behavioral—which contribute to the aging process. This research program is intended to produce the knowledge needed to prevent, modify or reverse the harmful aspects of aging and enhance the quality of the later years.

Institute scientists are working to distinguish aging from disease; identify the normal biological changes that accompany aging; understand the relationships between the aging process and the diseases related to advanced age; determine the psychological and social phenomena that contribute to and accompany changes with age; and develop the diagnostic, treatment and preventive procedures to apply this knowledge.

Research lies at the heart of solving such questions because, whether it is called basic or applied, research is the ultimate service. A comprehensive research plan was prepared by the Institute for the Department of Health, Education, and Welfare and presented to Congress, at its direction, earlier this year. The plan, entitled *Our Future Selves: A Research Plan Toward Understanding Aging* is designed to focus the resources of the government on all aspects of aging.

We recognize that research alone cannot accomplish the objective of a healthier and stronger older population, but the plan was offered as a reasonable and reasoned promise of a major endeavor to comprehend the nature of aging and its associated ills, with the ultimate aspiration of a more decent and dignified old age.

Far too many people, including professionals, see old age primarily as a time of chronic illness, failing mental abilities, dwindling bank accounts and stagnation. The vision of the plan extends beyond these concerns to the positive aspects of aging. Therefore, two basic ideas underlie the recommendations of the plan:

- Effective programs for the aged—whether medical or so-

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cial, treatment or prevention—must be based on knowing which changes in the aged are intrinsic to the aging process and which are not.

- If we are able to prevent or lessen the impact of non-intrinsic factors in the decline of the aged, then we are left with a unique and more satisfying concept of what aging is or should be—a natural stage in human development leading to a gradual and peaceful end.

Through research, and with the support of medical schools and physicians, knowledge can be increased and applied to serve the elderly.

The readiness of the medical community to join in this effort was indicated by a survey of practicing phycians, reported in the AMA's *IMPACT* (September, 1976) in which 75 per cent of respondents answered affirmatively to the question: "Do M.D.'s need special training in geriatrics?" Such training would, for example, make more physicians aware that in the later years multiple disorders are present as the body's protective mechanisms are comprised. Symptoms present differently in the old and the untrained clinician often misses the diagnoses:

- An older person with hyperthyrodism may appear apathetic, not hyperactive.
- Tuberculosis may proceed in silence.
- Appendicitis may occur without the characteristic abdominal tenderness at McBurney's point, without fever, and without an elevated white count.
- An older person may have a heart attack without chest pain and may instead appear confused, disoriented and seem like the victim of a stroke.

In the area of drugs, most practitioners have at some time been distressed by the adverse and often paradoxical reactions and interactions that occur because of multiple drug use by older people. Even so, the classic Goodman and Gilman textbook does not even have the word "age" in its index. Beleaguered by many other demands, the Food and Drug Administration has never really concentrated on the special variables of age, despite our knowledge that with age and with the severity of disease, the impact and the acute and long-term toxicity of drugs is altered. We know far too little about the age- and disease-related effects of the 1,500 different drugs prescribed each year. For example:

- The dosage of the anticoagulant warfarin needs to be lessened when given to a person taking chloral hydrate.
- There is a greater risk of bleeding when heparin is administered to women.
- There appears to be a link between reserpine and breast cancer in women.

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- Diazepam causes excessive drowsiness with age.

Learning more about various medications and their age-related effects is one type of basic research appropriate for the NIA. We need wise prescription guidelines in our work with older people, but first we need the scientific knowledge to enable us to develop such guidelines.

The special effect of diet on the condition of the elderly is not well enough understood. Nutrition has been shown to be the only environmental factor to increase the life span in animal model systems. Unfortunately, the nutritional status of aged persons is often poor. Undernutrition can be the key to an array of pathologies, such as intellectual confusion (so-called senility), and anemia, which could be reversed if adequate nutrition were provided. However, what constitutes "adequate nutrition" for aged persons is not fully known.

Most information on nutritional needs is based on research with children and young adults. But, because of changes in the physiology of the aged, such information is not likely to be applicable to the needs of this group. It would be of tremendous benefit to the aged to have valid guidelines for their nutritional requirements, including the need for vitamins, trace elements, fats, carbohydrates and proteins.

The Institute actively seeks the support of the medical community and public and private agencies to increase the total resources available to accomplish its research goals and to bring the old into the mainstream of American medicine.

*Research on Aging Act of 1974 (P.L. 93-296)

News Release

Donald W. Avery
Director of Public Relations
Telephone: 781-6470

SPRINGFIELD, MASS.—Individuals, young and old, can earn college credit for what they've learned on their own by taking College-Level Examinations offered during the third week of each month at Springfield Technical Community College. STCC is one of 1,800 colleges and universities that participate in the College-Level Examination Program (CLEP) of the College Entrance Examination Board and one of about 1,000 CLEP testing centers in the country.

College Board officials report that CLEP test-takers turn out in the greatest numbers in the spring and summer months: about 62% of all CLEP candidates in 1976 took the test between March and August.

The College Board reports that since the program was launched nationally in October, 1967, about 420,000 people have taken CLEP tests. In addition, more than 100,000 examinations are administered every year through the United States military's DANTES (Defense Activity for Nontraditional Education Support) program for servicemen and women and their dependents.

There are two types of CLEP examinations. General examinations test your knowledge of five basic liberal arts areas—English composition, mathematics, humanities, natural sciences, and social sciences-history. Another 47 examinations measure your knowledge of specific subjects such as American history, American literature, introductory accounting, computers and data processing, biology, and fundamentals of nursing. The exams cost $20 for one, $30 for two, and $40 for three to five. Further information about CLEP can be obtained from the Admissions-Registration Center at Springfield Technical Community College.

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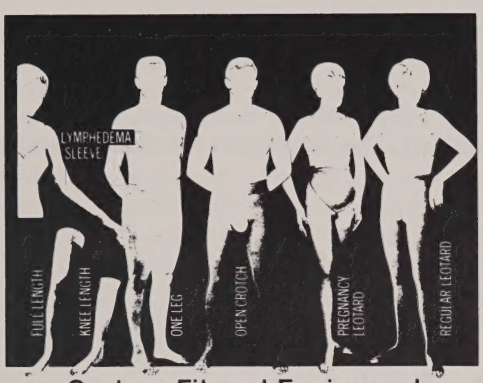

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Hobby Corner

Electronics is an appealing hobby, according to Mustafa Adham, Carl Janovsky and George Pelletier. There are several facets which can be explored by the hobbyist, including basic electronics, communications, entertainment devices, computers, and medical instrumentation. Considerable literature is available regarding the basics and there are several project booklets available—from the quite simple to the more complex. Most booklets explain the basic tools required and the technique of soldering. From there on, it is just a matter of deciding what to try first and then progress into more complicated projects as your interest and time dictate. Companies which are geared to provide hobbyists with informative booklets and projects include Heath Company (Benton Harbor, Michigan), Radio Shack, and EICO (283 Malta Street, Brooklyn). There are also several other lesser known companies.

In the past, projects were generally built around vacuum tubes, but today most everything is solid state (transistors and diodes) and a large share of solid state design is utilizing integrated circuits or so-called "circuit on a chip." The chip refers to a miniature chip of silicon on which are fashioned hundreds and even thousands of circuits—providing for devices such as the wrist radio and the multitude of miniature electronic devices available today.

The basic principles of electronics—amplification, rectification, and oscillation—still apply, but with the newer solid state designing, novel devices and applications are created regularly. You need only develop an interest and get a little experience in the basics and you will have endless hobby projects beckoning you.

Carl Janovsky, M.D.

The State of the Nation's Health

By Richard E. Palmer, M.D.
President, The American Medical Association

— No. 1 —

CHICAGO — What is the state of the nation's health?

It's good.

It's poor.

Both answers are correct. Statistics can be used to document either viewpoint.

Of course, no one agrees on what is healthy. There is no Dow Jones average or Richter scale to measure precisely whether a nation is or is not in the pink of health. But there are some guidelines that may be applied.

On balance, recent health gains appear to have outweighed the debits. Of the 10 leading causes of death five years ago, all but one have dropped. Our death rate now is the lowest in history.

But there are debits.

The cancer death rate is rising. Suicide and homicide are rising. The number of "slow down" days and days of bed illness per person per year have risen slightly. The proportion of the population that is handicapped by a chronic illness or injury is rising.

The average age of the American inches steadily up year after year, and as the population gets older more men and women live long enough to develop the chronic health problems that often accompany advancing years.

In 1967 there were 18.8 million Americans 65 years or more. By 1975 this figure had jumped to 22.3 million.

Another impediment to better health is one that seems to be deeply rooted in our national lifestyle. We tend to jeopardize our health by smoking, drinking, exercising little, eating too much. Swedes, who both smoke and drink substantially less than Americans, have a higher life expectancy.

Unemployment, inflation and environmental pollution are among the external factors affecting people's health adversely.

Two frequently used indicators of the nation's health are days of restricted activity per person, and the proportion of the population with long-term disabling infirmities. Both indicators are currently worsening.

In 1970 the nation averaged 8.5 slow-down days per person, and 6.1 bed days. In 1975 these two figures increased a bit, to 11.0 slow-down days and 6.6 bed days. The dif-

ferences weren't really large, but they do indicate that more people are feeling bad or actually ill. Perhaps the increasing age of the population is involved here.

The per cent of the population among which chronic conditions required limits to normal activity averaged 2.9 in 1970, but rose to 3.5 in 1975. And the proportion in which limitations were major, due to chronic health problems, rose from 8.0 to 10.8.

While the number of years of healthy life rose from the estimated mid-1960s level of 68.4 years to an estimated 70.2 in the mid-1970s, the average years of bed illness, hospitalization or institutionalization rose in the same period from an estimated 1.7 to 2.2. We are living longer, have more healthy years, but also have more invalid years.

There are some dark aspects of the state of the nation's health. America's physicians know this very well and they are working constantly to try to do something about them.

There are also many good things about the nation's health. And these will be discussed in a subsequent article.

— No. 2 —

CHICAGO — Americans are, overall, a healthy nation. And we're getting steadily healthier.

A previous article discussed some of the adverse aspects of the state of the nation's health. The cancer death rate is rising. The number of "slow down" days and days of bed illness per person per year have risen slightly.

But there most definitely is a bright side to the nation's health picture. Some of the pluses achieved in recent years have been little short of spectacular.

Maternal deaths were reduced by 26 per cent in just one year. Infant deaths have declined by 20 per cent in five years. Of the leading causes of death in 1970, rates for all but one—cancer—have been substantially reduced. Life expectancy has been increased by a year and a half since 1970.

From 1970 to 1975 deaths from heart disease dropped 6.4 per cent. Deaths from stroke in the same years declined by 9.9 per cent. Accidents as cause of death dropped by 15.6 per cent. Deaths from influenza and pneumonia declined by 12.6 per cent. And so on for the other leading causes of death.

In fact, fewer Americans are dying each year per 100,000 population. This ratio dropped by 5.2 per cent from 1970 to 1975. The category of bronchitis, emphysema and asthma is no longer among the top 10 killers. It's place was taken over by suicide.

Life expectancy at birth for all Americans in 1970 was 70.9 years. By 1975 the figure was up to 72.4 years. Since the turn of the century, when average life expectancy was 47.3 years, more than half a lifetime has been added.

Conspicuous gains have been reported in recent years against maternal deaths and deaths of infants. Maternal deaths per 100,000 live births dropped from 83.3 in 1950 to 10.8 in 1975. In the same quarter century, infant deaths (below the age of one year) dropped from 29.2 to 16.1 per 1,000 live births. Preliminary figures for 1976 indicate that the infant death rate has declined even more, to 15.2.

Americans are a healthy race, and they're getting healthier year by year.

A Summary of AMA, Medical and Health News

Commenting on a report by Ralph Nader's Health Research Group proposing a national Medicare fee schedule for physicians, AMA Board of Trustees Chairman Raymond T. Holden, MD, said: "The truth is that Medicare and Medicaid have not paid a fair reimbursement since 1971. While physicians must pay their office staffs at 1977 wage levels, and heat their offices at 1977 fuel prices, and buy professional liability insurance at 1977 premium rates, the government reimburses them at 1975 fee levels." He said the report's proposal to give HEW authority to withdraw hospital privileges of physicians who do not accept Medicare and Medicaid patients "constitutes a repugnant exercise in coercion, a clear abuse of federal power."

Public response to the AMA campaign against TV violence has been rapid and favorable. Letters and telephone calls to the Headquarters Office in support of the AMA's position have been received from concerned individuals and organizations; civic, educational and religious groups; law enforcement organizations; government agencies; congressional offices; medical societies; and the media.

A study prepared for HEW by David S. Salkever of Johns Hopkins U. and Thomas W. Bice of Washington U. shows that certificate of need controls don't work as they are supposed to. The study, titled "Impact of State Certificate of Need Laws on Health Care Costs and Utilization," points to "the (perhaps) surprising conclusion that certificate of need controls have contributed to cost inflation . . ." The authors said, "our findings signal the need for a much more thorough and detailed study of the effectiveness of certificate of need regulation as a cost-control device."

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Medicare in Canada

Regulated physician's medicare health insurance in Canada, in some form, dates back to the 1930's. In its present format, Canada's national medicare insurance dates from 1968. The cost-sharing agreements on hospital insurance date back to the 1950's. Although Canada's medicare is pointed to as the way to go by some of the proponents of NHI in the United States, their system operates far differently than the proposals presently being discussed in Congress.

In the first place, Canadian federal government involvement in medicare is mainly financial—presently, on the average, 50% of the provincial programs' funding. In the beginning, the federal government set out guidelines which had to be met by the provincial medicare programs before the 50% funding was made available. By this means the federal government assured a high degree of comparability in the provincial programs.

The Canadian federal government is currently expressing concern about their lack of control on expenditures. Originally, the feds agreed to pay their share without control on costs at the level of service. In order to gain some control in the future, the federal government will be limiting the growth of its expenditures to the provincial governments by an annual percentage that supposedly bears some relationship to the growth of the economy. For the first few years the sharing percentage paid to the provinces will be on a gradually reducing basis. Thereafter, it will be set annually by the national legislature.

The big difference between proposals put forth in the United States and the way national medicare works in Canada is that their government in Ottawa does *not* issue voluminous and contradictory rules and regulations as do our HEW and other agencies. Rule-making is primarily a function of the provincial health services, as long as their rules fall within the federal guidelines. Data and statistics are gathered by both the provincial and federal governments and furnished regularly to the medical societies in both raw and final format.

The provincial medical societies are the spokesmen for physicians. They are lobbyists, negotiators and overseers for the profession. Except for the province of Quebec, where there are separate provincial societies for general practitioners and for specialists, the provincial societies represent all physicians. The independent and uncoordinated directions and interests followed by the multiple specialty and sub-specialty societies in the United States is much less prevalent in Canada. Effectively, and with the cooperation of all members, the

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Medicare in Canada — Continued

Canadian societies represent the profession, with the specialty groups coordinating their efforts under the umbrella of the provincial society.

Negotiations with provincial governments, presently limited under federal anti-inflation regulations, are concerned with developing a percentage increase applicable to fee-payment schedules for the provinces. This increase is then distributed through the provincial medical societies, in most cases, between the inter-specialty groups with individual fee schedules being adjusted accordingly. Fee schedules are generally of a relative value nature, with specific amounts being allocated to IBM-numbered procedures. These negotiated payment schedules are then recognized and paid for by the provinces.

Some provincial medical societies also negotiate for salaried physicians and for "sessional" rates. Salaried physicians, who are mainly employees of the provincial governments, are, except in very few instances, members of the medical societies. Negotiations, however, cover the full range of economic and other benefits usually negotiated by labor unions. Sessional fees relate to limited periods of service by fee-for-service physicians, usually of three- or four-hour duration. Sessional service is usually performed in a variety of institutions and may range from as little as one session per month to several per week.

The most interesting aspect of the Canadian medical profession—governmental relations to an American physician is the ambience of the specialty groups within the provincial society. Whatever the reason—whether it was the knowledge that, failing to

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work together they could be whipsawed and restrained by provincial governments, or that together they would be able to better police and promote the profession relatively free of non-professional interference in their practices—the fact remains that, to the public and to the governments, they present a united front. This unity has minimized government interference in most provinces, and puts the societies in the position of being sought after by their governments for consultations and recommendations on such varied subjects as medical services allocation, licensing physician discipline, training and physician placement.

While the medical profession in the United States may not agree with the Canadian federal system of universal health insurance, they can learn a lesson from the experience of their peers to the North in working together for their mutual benefit.

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From the AMA Department of Negotiations—

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